

FINAL INSPECTION REPORT
Under the *Retirement Homes Act, 2010*

Inspection Information	
Date of Inspection: August 25, 2014	Name of Inspector: Debbie Rydall
Inspection Type: Routine Inspection	
Licensee: Caessant Care Nursing and Retirement Homes Limited / 264 Norwich Avenue, Woodstock, ON N4S 3V9 (the "Licensee")	
Retirement Home: Caessant Care - Harriston / 24 Louise Street, Harriston, ON N0G 1Z0 (the "home")	
Licence Number: T0033	

Purpose of Inspection
The RHRA conducts routine inspections as set out in section 77(3) of the <i>Retirement Homes Act, 2010</i> (the "RHA").

NON-COMPLIANCE
<p>1. The Licensee failed to comply with O. Reg. 166/11, s. 11; Posted information.</p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p>11. (1) For the purposes of paragraph 4 of subsection 55 (2) of the Act, the following information is prescribed as information that must be posted in a retirement home under that subsection:</p> <p>3. An explanation of the procedures to be followed in the case of an evacuation.</p>
<p>Inspection Finding</p> <p>An explanation of the procedures to follow in the case of an evacuation were not posted in the home as is required by the legislation.</p>
<p>Outcome</p> <p>Corrective action taken by the Licensee.</p>
<p>2. The Licensee failed to comply with O. Reg. 166/11, s. 24; Emergency plan, general.</p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p>24. (5) The licensee shall,</p> <p>(a) on an annual basis at least, test the emergency plan, including arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency, related to,</p>

- (i) the loss of essential services,
 - (ii) situations involving a missing resident,
 - (iii) medical emergencies,
 - (iv) violent outbursts;
- (c) keep a written record of the testing of the emergency plan and planned evacuations and of any changes made to improve the emergency plan.

Inspection Finding

The home has not completed the annual testing of its emergency plan as is required by the legislation.

Outcome

Corrective action taken by the Licensee.

3. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 65; Training.

Specifically, the Licensee failed to comply with the following subsection(s):

65. (2) Every licensee of a retirement home shall ensure that no staff work in the home unless they have received training in,

- (a) the Residents’ Bill of Rights;
- (b) the licensee’s policy mentioned in subsection 67 (4) to promote zero tolerance of abuse and neglect of residents;
- (c) the protection afforded for whistle-blowing described in section 115;
- (d) the licensee’s policy mentioned in subsection 68 (3) regarding the use of personal assistance services devices for residents;
- (f) fire prevention and safety;
- (h) the emergency plan and the infection prevention and control program of the licensee for the home mentioned in subsection 60 (4);

Inspection Finding

The employee file for the most recently hired employee was reviewed and there was no evidence to support that she had received the required training prior to starting to work in the home as is required by the legislation. Two staff members confirmed that the required training is not provided prior to starting work in the home.

Outcome

Corrective action taken by the Licensee.

4. The Licensee failed to comply with O. Reg. 166/11, s. 15; Policy of zero tolerance of abuse and neglect.

Specifically, the Licensee failed to comply with the following subsection(s):

15. (3) The policy to promote zero tolerance of abuse and neglect of residents described in subsection 67 (4) of the Act shall,

(d) provide that the licensee of the retirement home shall ensure that the resident’s substitute decision-makers, if any, and any other person specified by the resident,

(i) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of a resident that has resulted in a physical injury or pain to a resident or that causes distress to a resident that could potentially be detrimental to a resident’s health or well-being,

(ii) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of a resident;

(e) provide that the licensee of the retirement home shall ensure that the resident and the resident’s substitute decision-makers, if any, are notified of the results of an investigation described in clause 67 (5) (e) of the Act immediately upon the completion of the investigation;

(f) provide that the licensee of the retirement home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence;

Inspection Finding

The home has a prevention of abuse and neglect policy in place; however the policy is not aligned with the legislative requirements. Specifically, the policy does not include the specific time frame for the notification of family or that the resident/SDM will be notified of the results of the investigation. The policy includes police notification relating to potential incidents of staff to resident or family to resident abuse but does not include that the home will notify the police relating to incidents of resident to resident abuse.

Outcome

Corrective action taken by the Licensee.

5. The Licensee failed to comply with O. Reg. 166/11, s. 22; Risk of falls.

Specifically, the Licensee failed to comply with the following subsection(s):

22. (1) Every licensee of a retirement home shall develop, document and implement strategies to reduce or mitigate the risk of falls in common areas of the home.

Inspection Finding

The home has a falls assessment tool in place; however they have not developed strategies to mitigate the risk of falls in common areas of the home as is required by the legislation.

Outcome


Corrective action taken by the Licensee.

NOTICE

The Final Inspection Report is being provided to the Licensee, the Registrar of the Retirement Homes Regulatory Authority (the "RHRA") and the home's Residents' Council, if any.

Section 55 of the RHA requires that the Final Inspection Report be posted in the home in a conspicuous and easily accessible location. In addition, the Licensee must ensure that copies of every Final Inspection Report from the previous two (2) years are made available in the Home, in an easily accessible location.

The Registrar's copy of the Final Inspection Report, as it appears here, will be included on the RHRA Public Register, available online at <http://rhra.ca/en/register/>

Signature of Inspector 	Date September 22, 2014
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